MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Edward Wolski, M.D. / Wol+Med 2436 I-35 E. South, Ste. 336 Denton, TX 76205	MDR Tracking No.: M4-03-8448-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Lumbermen's Mutual Casualty Co. P.O. Box 749010 Dallas, TX 75374 Box 42	Date of Injury: Employer's Name: Johnson & Johnson Insurance Carrier's No.: 4210032243

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
07/10/02	07/10/02	99213	$48.00	$48.00

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 7/29/03 states in part, "…Date of service 7/10/02-The carrier failed to respond to our initial billing, and to the request for reconsideration. Confirmation of the carrier's receipt of these billings was enclosed initially…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary not submitted with response. However, the Respondent's rationale listed on the Table of Disputed Services states, "Billing for date of service 7-10-02 never received".

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 99213 for date of service 07/10/02. Neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the Requestor has submitted convincing evidence of proof of delivery. However, per the 1996 MFG/Evaluation & Management Ground Rule (IV)(C) the Requestor did not submit SOAP notes for the disputed date of service; MDR cannot confirm services were rendered as billed. Reimbursement is not recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement.

Ordered by:

	Marguerite Foster	02/11/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____